CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Provider Operations

(Amended After Comments)

907 KAR 3:005. Coverage of physicians' services.

RELATES TO: KRS 205.520, 205.560, 42 C.F.R. 415.152, 415.174, 415.184, 440.50, 447.26, 45 C.F.R. 160, 164, 42 U.S.C. 1320 - 1320d-8, 1396a(a)(19), (30)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(1)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes the Medicaid Program coverage provisions and requirements[~~provisions~~] relating to physicians' services[~~ for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and the medically needy~~].

Section 1. Definitions. (1) [~~"Biological" means the definition of "biologicals" pursuant to 42 U.S.C. 1395x(t)(1).~~

~~(2)~~] "Common practice" means **an arrangement through[~~a contractual partnership in~~]** which a physician assistant administers health care services under the

[~~employment and~~] supervision of a physician **via a supervisory relationship that has been approved by the Kentucky Board of Medical Licensure**.

(2)[~~(3) "Comprehensive choices" means a benefit plan for an individual who:~~

~~(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. A nursing facility in accordance with 907 KAR 1:022;~~

~~2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;~~

~~3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or~~

~~4. The Model Waiver II Program in accordance with 907 KAR 1:595; and~~

~~(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.~~

~~(4)~~] "CPT code" means a code used for reporting procedures and services performed by medical practitioners[~~physicians~~] and published annually by the American Medical Association in Current Procedural Terminology.

(3)[~~(5)~~] "Department" means the Department for Medicaid Services or its designee.

(4) "Designated controlled substance provider" means the provider designated as a lock-in recipient's controlled substance prescriber**:**

1. Pursuant to 907 KAR 1:677 **if the recipient is not an enrollee; or**

2. As established by the managed care organization in which the lock-in recipient is enrolled if the lock-in recipient is an enrollee.

(5) "Designated primary care provider" means the provider designated as a lock-in recipient's primary care provider**:**

1. Pursuant to 907 KAR 1:677 **if the recipient is not an enrollee; or**

2. As established by the managed care organization in which the lock-in recipient is enrolled if the lock-in recipient is an enrollee.

(6) "Direct physician contact" means that the billing physician is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(7) "Early and periodic screening and diagnosis and treatment" or "EPSDT" is defined by 42 C.F.R. 440.40(b).[~~"Drug" means the definition of "drugs" pursuant to 42 U.S.C. 1395x(t)(1).~~]

(8) "Emergency care" means:

(a) Covered inpatient or[~~and~~]outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; or

(b) Emergency ambulance transport.

(9) "Enrollee" means a recipient who is enrolled with a managed care organization.

(10) "Federal financial participation" is defined by 42 C.F.R. 400.203.[~~"EPSDT" means early and periodic screening, diagnosis, and treatment.~~

~~(10) "Family choices" means a benefit plan for an individual who:~~

~~(a) Is covered pursuant to:~~

~~(a) 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u - 1;~~

~~(b) 42 U.S.C. 1396a(a)(52) and 1396r - 6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);~~

~~c. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);~~

~~c. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);~~

~~d. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or~~

~~(e. Has a designated package code of 2, 3, 4, or 5.~~]

(11) "Global period" means [~~occurring during~~] the period of time in which related pre-operative, intraoperative, and postoperative services and follow-up care for a surgical procedure are customarily provided.

(12)[~~"Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:~~

~~(a) Caretaker relatives who:~~

~~1. Receive Kentucky Transitional Assistance Program (K-TAP) benefits and are deprived due to death, incapacity, or absence;~~

~~2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or~~

~~3. Do not receive K-TAP benefits and are deprived due to unemployment;~~

~~(b) Individuals aged sixty-five (65) and over who receive Supplemental Security Income (SSI) benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~

~~2. Receive State Supplementations Program (SSP) benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(c) Blind individuals who receive SSI benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~

~~2. SSP benefits, and do not meet nursing facility patient status criteria in accordance~~

~~with 907 KAR 1:022;~~

~~(d) Disabled individuals who receive SSI benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or~~

~~2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;~~

~~(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022; or~~

~~(h) Pregnant women.~~

~~(13)~~] "Graduate medical education program" or "GME Program" means [~~one (1) of the following~~]:

(a) A residency program approved by:

1. The Accreditation Council for Graduate Medical Education of the American Medical Association;

2. The Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;

3. The Commission on Dental Accreditation of the American Dental Association; or

4. The Council on Podiatric Medicine Education of the American Podiatric Medical Association; or

(b) An approved medical residency program as defined in 42 C.F.R. 413.75(b).

(13)[~~(14)~~] "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:

(a) Requires little additional resources; or

(b) Is clinically integral to the performance of the primary procedure.

(14)[~~(15)~~] "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(15) "Lock-in recipient" means**:**

(a) A recipient enrolled in the lock-in program in accordance with 907 KAR 1:677**; or**

(b) An enrollee enrolled in a managed care organization's lock-in program pursuant to 907 KAR 17:020, Section 8.

(16)[~~"KenPAC" means the Kentucky Patient Access and Care System.~~

~~(17) "KenPAC PCP" means a Medicaid provider who is enrolled as a primary care provider in the Kentucky Patient Access and Care System.~~

~~(18)~~] "Locum tenens" means a substitute physician:

(a) Who temporarily assumes responsibility for the professional practice of a physician participating in the Kentucky Medicaid Program; and

(b) Whose services are paid under the participating physician's provider number.

(17) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42

C.F.R. 438.2.

(18) "Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient as a Medicaid-participating provider in accordance with:

1. 907 KAR 1:671; and

2. 907 KAR 1:672;

(b) The Medicaid Program is the payer for the service; and

(c) The recipient is not liable for payment to the provider for the service other than any cost sharing obligation owed by the recipient to the provider.

(19) "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(20) "Medical resident" means [~~one (1) of the following~~]:

(a) An individual who participates in an approved graduate medical education (GME) program in medicine or osteopathy; or

(b) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, including:

1. An individual with a:

a. Temporary license;

b. Resident training license; or

c. Restricted license; or

2. An unlicensed graduate of a foreign medical school.

(21) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one another during the same

patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically impossible or improbable use of CPT codes; or

(d) Are described in Current Procedural Terminology as inappropriate coding of procedure combinations.

(22) "Non-Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient;

(b) The Medicaid Program is not the payer for the service; and

(c) The recipient is liable for payment to the provider for the service.

(23)[~~"Optimum choices" means a benefit plan for an individual who:~~

~~(a) Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. An intermediate care facility for individuals with an intellectual disability in accordance with 907 KAR 1:022; or~~

~~2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and~~

~~(c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.~~]

(24)[~~(23)~~] "Other licensed medical professional" means a health care provider other than a physician, physician assistant, advanced practice registered nurse[~~practitioner~~], certified registered nurse anesthetist, nurse midwife, or registered nurse who has been approved to practice a medical specialty by the appropriate licensure board.

(25) "Other provider preventable condition" is defined in 42 C.F.R. 447.26(b).

(26)[~~(24)~~] "Physician assistant" is defined in KRS 311.840(3).

(27) "Physician injectable drug" means an injectable, infused, or inhaled drug or biological that:

(a) Is not typically self-administered;

(b) Is not excluded as a noncovered immunization or vaccine;

(c) Requires special handling, storage, shipping, dosing, or administration; and

(d) Is a rebatable drug.

(28) "Podiatrist" is defined by KRS 205.510(12).

(29) "Rebatable drug" means a drug for which the drug's manufacturer has entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(30) "Recipient" is defined by KRS 205.8541(9).

(31)[~~(25)~~] "Screening" means the evaluation of a recipient by a physician to determine:

(a) If [~~The presence of~~] a disease or medical condition is present; and

(b) If further evaluation, diagnostic testing, or treatment is needed.

(32) [~~(26) "Special handling, storage, shipping, dosing or administration" means one (1) or more of the following requirements as described in the dosing and administration section of a medication's package insert:~~

~~(a) Refrigeration of the medication;~~

~~(b) Protection from light until time of use;~~

~~(c) Overnight delivery;~~

~~(d) Avoidance of shaking or freezing; or~~

~~(e) Other protective measures not required for most orally-administered medications.~~

~~(27)~~] "Supervising physician" is defined in KRS 311.840(4).

(33)[~~(28)~~] "Supervision" is defined in KRS 311.840(6).

(34)[~~(29)~~] "Timely filing" means receipt of a Medicaid claim by the department[~~ Medicaid~~]:

(a) Within twelve (12) months of the date the service was provided;

(b) Within twelve (12) months of the date retroactive eligibility was established; or

(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.

(35)[~~(30)~~] "Unlisted procedure or service" means a procedure:

(a) For which there is not a specific CPT code; and

(b) Which is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Conditions of Participation. (1)(a) A participating physician shall:

1. Be licensed as a physician in the state in which the medical practice is located;

2. Comply with the:

a. Terms and conditions established in 907 KAR 1:005, 907 KAR 1:671, and 907 KAR 1:672;

b. Requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164;

3. Have the freedom to choose whether to provide services to a recipient; and

4. Notify the recipient referenced in paragraph (b) of this subsection of the provider's decision to accept or not accept the recipient on a Medicaid basis prior to providing any service to the recipient.

(b) A provider may provide a service to a recipient on a non-Medicaid basis:

1. If the recipient agrees to receive the service on a non-Medicaid basis; and

2. Whether or not the:

a. Provider is a Medicaid-participating provider; or

b. Service is a Medicaid-covered service.

(2)[~~A participating physician shall comply with the terms and conditions established in the following administrative regulations:~~

~~(a) 907 KAR 1:005, Nonduplication of payments;~~

~~(b) 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions; and~~

~~(c) 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation.~~

~~(3) A participating physician shall comply with the requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.~~

~~(4) A participating physician shall have the freedom to choose whether to accept an eligible Medicaid recipient and shall notify the recipient of that decision prior to the delivery of service.~~] If a[~~the~~] provider agrees to provide services to a[~~accepts the~~] recipient, the provider:

(a) Shall bill the department[~~Medicaid~~]rather than the recipient for a covered service;

(b) May bill the recipient for a service not covered by Medicaid if the physician informed the recipient of noncoverage prior to providing the service; and

(c) Shall not bill the recipient for a service that is denied by the department on the

basis of:

1. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;

2. Incorrect billing procedures, including incorrect bundling of services;

3. Failure to obtain prior authorization for the service; or

4. Failure to meet timely filing requirements.

(3)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(4)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(5)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secre-

tary shall be the required period.

(6) A provider shall comply with 45 C.F.R. Part 164.

Section 3. Covered Services. (1) To be covered by the department, a service shall be:

(a) Medically necessary;

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;

(c) Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and

(d) Eligible for reimbursement as a physician service.

(2) Direct physician contact between the billing physician and recipient shall not be required for:

(a) A service provided by a:

1. Medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;

2.[~~(b) A service provided by a~~] Locum tenens physician who provides direct physician contact; or

3. Physician assistant in accordance with Section 7 of this administrative regulation;

(b)[~~(c)~~] A radiology service, imaging service, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;

(c)[~~(d)~~] The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;

(d)[~~(e)~~] A [~~preauthorized~~]sleep disorder service[~~ if provided in a physician operated and supervised sleep disorder diagnostic center~~]; or

(e)[~~(f)~~] A telehealth consultation provided [~~by a consulting medical specialist~~]in accordance with 907 KAR 3:170[~~; or~~

~~(g) A service provided by a physician assistant in accordance with Section 7 of this administrative regulation~~].

(3) A service provided by an [~~individual who meets the definition of~~]other licensed medical professional shall be covered if the other licensed medical professional is:

(a) [~~The individual is~~]Employed by the supervising physician; and

(b) [~~The individual is~~]Licensed in the state of practice[~~; and~~

~~(c) The supervising physician has direct physician contact with the recipient~~].

(4) A sleep disorder service shall be covered if performed in:

(a) A hospital; or

(b)1. A sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the:

a. American Sleep Disorders Association; or

b. American Academy of Sleep Medicine; or

2. An independent diagnostic testing facility that:

a. Is supervised by a physician trained in analyzing and interpreting sleep disorder recordings; and

b. Has documentation demonstrating that it complies with criteria approved by the:

(i) American Sleep Disorders Association; or

(ii) American Academy of Sleep Medicine

Section 4. Service Limitations. (1) A covered service provided to a lock-in recipient [~~placed in "lock-in" status in accordance with 907 KAR 1:677~~]shall be limited to a service provided by the lock-in recipient's designated primary care provider or designated controlled substance prescriber[~~lock-in provider~~] unless:

(a) The service represents emergency care; or

(b) The lock-in recipient has been referred to the provider by the lock-in recipient's designated primary care provider[~~by the "lock-in" provider~~].

(2) An EPSDT screening service shall be covered in accordance with 907 KAR 11:034[~~Sections 3 through 5~~].

(3) A laboratory procedure performed in a physician's office shall be limited to a procedure for which the physician has been certified in accordance with 42 C.F.R. Part 493.

(4) **Except for the following, a drug administered in a physician's office shall not be covered as a separate reimbursable service through the physicians' program:**

(a) Rho (D) immune globulin injection;

(b) An injectable antineoplastic drug;

(c) Medroxyprogesterone acetate for contraceptive use, 150 mg;

(d) Penicillin G benzathine injection;

(e) Ceftriaxone sodium injection;

(f) Intravenous immune globulin injection;

(g) Sodium hyaluronate or hylan G-F for intra-articular injection;

(h) An intrauterine contraceptive device;

(i) An implantable contraceptive device;

(j) Long acting injectable risperidone; or

(k) An injectable, infused or inhaled drug or biological that:

1. Is not typically self-administered;

2. Is not excluded as a noncovered immunization or vaccine; and

3. Requires special handling, storage, shipping, dosing or administration.

(5)[~~Except for the following, a drug administered in the physician's office shall not be covered as a separate reimbursable service through the physician program:~~

~~(a) Rho (D) immune globulin injection;~~

~~(b) An injectable antineoplastic drug;~~

~~(c) Medroxyprogesterone acetate for contraceptive use, 150 mg;~~

~~(d) Penicillin G benzathine injection;~~

~~(e) Ceftriaxone sodium injection;~~

~~(f) Intravenous immune globulin injection;~~

~~(g) Sodium hyaluronate or hylan G-F for intra-articular injection;~~

~~(h) An intrauterine contraceptive device; or~~

~~(i) An implantable contraceptive device~~

~~(j) Long acting injectable risperidone; or~~

~~(k) An injectable, infused or inhaled drug or biological that:~~

~~1. Is not typically self-administered;~~

~~2. Is not excluded as a noncovered immunization or vaccine; and~~

~~3. Requires special handling, storage, shipping, dosing or administration.~~

~~(5)~~] A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F,

shall be covered within the scope and limitations of 42 C.F.R. 441, Subpart E and Subpart F[~~the federal regulations~~].

(6)[~~(5)~~][~~(6)~~] Coverage for:

(a) A service designated as a psychiatry service CPT code and provided by a physician other than a board certified or board eligible psychiatrist or an advanced practice registered nurse with a specialty in psychiatry shall be limited to four (4) services, per physician, per recipient, per twelve (12) months;

(b)[~~.~~

~~(7)(a) Coverage for~~] An evaluation and management service shall be limited to one (1) per physician, per recipient, per date of service; or

(c)[~~.~~

~~(b) Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician.~~

~~(8) Coverage for~~] A fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(7)[~~(6)~~][~~(9)(a)~~] An anesthesia service shall be covered if:

(a) Administered by:

1. An anesthesiologist who remains in attendance throughout the procedure; or

2. An individual who:

a. Is licensed in Kentucky to practice anesthesia;

b. Is licensed in Kentucky within his or her scope of practice; and

c. Remains in attendance throughout the procedure;

(b) Medically necessary; and

(c) Not provided as part of an all-inclusive CPT code.

(8)[~~(7)~~][~~administered by an anesthesiologist who remains in attendance throughout the procedure;~~

~~(b) Except for An anesthesia service provided by an oral surgeon, an anesthesia service, including conscious sedation, provided by a physician performing the surgery shall not be covered.~~

~~(10)~~] The following [~~services~~]shall not be covered:

(a) An acupuncture service;

(b) [~~Allergy immunotherapy for a recipient age twenty-one (21) years or older;~~

~~(c)~~] An autopsy;

(c)[~~(d)~~] A cast or splint application in excess of the limits established in 907 KAR 3:010[~~, Section 4(5) and (6)~~];

(d)[~~(e)~~] Except for therapeutic bandage lenses, contact lenses;

(e)[~~(f)~~] A hysterectomy performed for the purpose of sterilization;

(f)[~~(g)~~] Lasik surgery;

(g)[~~(h)~~] Paternity testing;

(h)[~~(i)~~] A procedure performed for cosmetic purposes only;

(i)[~~(j)~~] A procedure performed to promote or improve fertility;

(j)[~~(k)~~] Radial keratotomy;

(k)[~~(l)~~] A thermogram;

(l)[~~(m)~~] An experimental service which is not in accordance with current standards of medical practice; [~~or~~]

(m)[~~(n)~~] A service which does not meet the requirements established in Section 3(1) of this administrative regulation;

(n) Medical direction of an anesthesia service; or

(o) Medical assistance for an other provider preventable condition in accordance with 907 KAR 14:005.

Section 5. Prior Authorization Requirements for Recipients Who are Not Enrolled with a Managed Care Organization[~~ and KenPAC Referral Requirements~~]. (1) The following procedures for a recipient who is not enrolled with a managed care organization shall require prior authorization by the department:

(a) Magnetic resonance imaging[~~(MRI)~~];

(b) Magnetic resonance angiogram[~~(MRA)~~];

(c) Magnetic resonance spectroscopy;

(d) Positron emission tomography[~~ (PET)~~];

(e) Cineradiography or videoradiography[~~video radiography~~];

(f) Xeroradiography;

(g) Ultrasound subsequent to second obstetric ultrasound;

(h) Myocardial imaging;

(i) Cardiac blood pool imaging;

(j) Radiopharmaceutical procedures;

(k) Gastric restrictive surgery or gastric bypass surgery;

(l) A procedure that is commonly performed for cosmetic purposes;

(m) A surgical procedure that requires completion of a federal consent form; or

(n) An unlisted covered procedure or service.

(2)(a) Prior authorization by the department shall not be a guarantee of recipient eligibility.

(b) Eligibility verification shall be the responsibility of the provider.

(3) The prior authorization requirements established in subsection (1) of this section shall not apply to:

(a) An emergency service; or

(b) A radiology procedure if the recipient has a cancer or transplant diagnosis code.

(4) A referring physician, a physician who wishes to provide a given service, a podiatrist, a chiropractor, or an advanced practice registered nurse:

(a)[~~practitioner~~] May request prior authorization from the department; and

(b) If requesting prior authorization,[~~.~~

~~(5) A referring physician, a physician who wishes to provide a given service, or an advanced registered nurse practitioner~~] shall request prior authorization by:

1. Mailing or faxing:

a.[~~(a)~~] A written request to the department with [~~sufficient~~]information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation; and

b.[~~(b)~~] If applicable, any required federal consent forms; or

2. Submitting a request via the department's web-based portal with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation.[~~(6) Except for a service specified in 907 KAR 1:320, Section 10(3)(a) through (q), a referral from the KenPAC PCP shall be required for a recipient enrolled in the KenPAC Program.~~]

Section 6. Therapy Service Limits. (1) Speech language pathology services[~~therapy~~] shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section[~~:~~

~~(a) Ten (10) visits per twelve (12) months for a recipient of the Global Choices benefit plan;~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit plan; or~~

~~2. Optimum Choices benefit plan~~].

(2) Physical therapy services shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section[~~:~~

~~(a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices benefit plan; or~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit plan; or~~

~~2. Optimum Choices benefit plan~~].

(3) Occupational therapy services shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section[~~:~~

~~(a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices benefit plan; or~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit plan; or~~

~~2. Optimum Choices benefit plan~~].

(4) A service in excess of the [~~therapy~~] limits established in subsection (1) through (3)

of this section shall be exceeded[~~over-ridden~~] if the additional service is determined to be medically necessary by:

(a) The department if the recipient is not enrolled with a managed care organization; or

(b) Managed care organization in which the enrollee is enrolled if the recipient is an enrollee[~~determines that additional visits beyond the limit are medically necessary.~~

~~(5)(a) To request an override:~~

~~1. The provider shall telephone or fax the request to the department; and~~

~~2. The department shall review the request in accordance with the provisions of 907 KAR 3:130 and notify the provider of its decision.~~

~~(b) An appeal of a denial regarding a requested override shall be in accordance with 907 KAR 1:563.~~

~~(6) The limits established in subsections (1), (2), and (3) of this section shall not apply to a recipient under twenty-one (21) years of age. Except for recipients under age twenty-one (21), prior authorization shall be required for each visit that exceeds the limit established in subsection (1) through (3) of this section~~].

Section 7. Physician Assistant Services. (1) Except for[~~With the exception of~~] a service limitation specified in subsections (2) or (3) of this section, a service provided by a physician assistant in common practice with a Medicaid-enrolled physician shall be covered if:

(a) The service meets the requirements established in Section 3(1) of this administrative regulation;

(b) The service is within the legal scope of certification of the physician assistant;

(c) The service is billed under the physician's individual provider number with the physician assistant's number included; and

(d) The physician assistant complies with:

1. KRS 311.840 to 311.862; and

2. Section 2(1)(b)[~~Sections 2(2) and (3)~~] of this administrative regulation.

(2) A same service performed by a physician assistant and a physician on the same day within a common practice shall be considered as one (1) covered service.

(3) The following physician assistant services shall not be covered:

(a) A physician noncovered service specified in Section 4(9)[~~Section 4(10)~~] of this administrative regulation;

(b) An anesthesia service;

(c) An obstetrical delivery service; or

(d) A service provided in assistance of surgery.

Section 8. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the same service provided to the same recipient during the same time period via the physician services program.

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

Section 10. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the require-

ments established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

Section 11. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 12. Federal Approval and Federal Financial Participation. The department’s coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services’ approval for the coverage.

Section 13. Appeal Rights. [~~(1)~~] An appeal of a department decision regarding:

(1) A Medicaid recipient who is not enrolled with a managed care organization based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563; or

(2) An enrollee based upon an application of this administrative regulation shall be in accordance with 907 KAR 17:010. [~~(2) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.~~

~~(3) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.~~]

907 KAR 3:005

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 3:005
Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid program coverage provisions and requirements regarding physician services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Medicaid program coverage provisions and requirements regarding physician services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid program coverage provisions and requirements regarding physician services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the Medicaid program coverage provisions and requirements regarding physician services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendments include authorizing Medicaid reimbursement for allergy immunotherapy for all ages [the current version of the administrative regulation does not authorize such coverage for individuals twenty-one (21) and over]; revising the speech pathology service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; revising the physical therapy service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; revising the occupational therapy service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; deleting references to the four (4) Medicaid benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years; establishing that the Department for Medicaid Services (DMS) won’t reimburse for medical direction of an anesthesia service and won’t reimburse for an anesthesia service that is included as part of an all-inclusive CPT code; establishing that a sleep disorder service must be performed in a hospital, sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the American Sleep Disorders

Association or American Academy of Sleep Medicine, or independent diagnostic testing facility that is supervised by a physician training in analyzing and interpreting sleep disorder recordings and if the testing facility has the aforementioned documentation required for sleep laboratories; establishing that DMS won't reimburse for an "other provider preventable condition" (this is a condition which resulted from a provider's neglect and was not present in the recipient when the recipient appeared at the provider's office to receive a service); adding podiatrists and chiropractors as providers eligible to request prior authorization for a service; establishing an option for providers to request prior authorization for services through an internet portal; establishing that the Department for Medicaid Services' (DMS's) coverage of services is contingent upon federal approval and funding; and establishing that the relevant administrative regulation for services' related appeals for an individual who is enrolled with a managed care organization is 907 KAR 17:010. The amendment after comments re-inserts provisions regarding DMS's coverage of physician injectable drugs and related drugs in a physician's office; clarifies the definition of "common practice"; and also clarifies lock-in program provisions regarding managed care organizations. The lock-in program is a program in which individuals who are determined to excessively/inappropriately utilize services are locked in to using certain authorized providers.

(b) The necessity of the amendment to this administrative regulation: The amendment which eliminates the age cap on allergy immunotherapy and the amendment which sets a uniform limit of twenty (20) therapy service visits per calendar year are necessary to synchronize DMS's coverage of therapy services and of allergy immunotherapy with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provider coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year and covers allergy immunotherapy for all ages, DMS is adopting the same policies. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.) Consequently, DMS is concurrently repealing the administrative regulation which establishes the four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years.

The four (4) benefit plans vary little and DMS is establishing one (1) benefit plan for all Medicaid recipients including the new groups mandated or authorized by the Affordable Care Act. Additionally, there is an administrative and Medicaid Management Information System (MMIS) burden associated with preserving different plans as well as an administrative burden on providers and managed care organizations. Given that the plans vary little it is impractical if not inefficient to preserve the plans. The amendments regarding anesthesia are necessary to ensure appropriate utilization of services. The amendment regarding a sleep disorder service is necessary to ensure recipients are served by a provider that meets national industry standards. Establishing that DMS won't reimburse for an "other provider preventable condition" is necessary to comply with a federal mandate. Authorizing chiropractors and podiatrists to request prior authorization is necessary to enhance recipient access to services; establishing an option for providers to request prior authorization online is necessary to expedite the delivery of services; establishing that DMS's coverage of services is contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer monies; and establishing that appeals for a recipient enrolled with a managed care organization will be done in accordance with the relevant managed care organization regulation is necessary as such appeals are in the domain of managed care organizations. The amendment after comments which re-inserts physician injectable drug and related provisions) is necessary as DMS continues to cover physician injectable and related drugs administered in a physician's office. The amendment after comments regarding lock-in programs and managed care organizations is necessary to clarify that managed care organizations do not have to employ the same lock-in program criteria used by DMS (pursuant to DMS's lock-in administrative regulation – 907 KAR 1:677.) Revising the definition of "common practice" is necessary for clarity.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting with the Affordable Care Act, enhancing the health, safety, and welfare of Medicaid recipients, facilitating providers' ability to request prior authorizations, and protecting Kentucky taxpayer monies. The amendment after comments conforms to the content of the authorizing statutes by clarifying policies.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by comporting with the Affordable Care Act, enhancing the health, safety, and welfare of Medicaid recipients, facilitating providers' ability to request prior authorizations, and protecting Kentucky taxpayer monies. The amendment after comments assists in the effective administration of the authorizing statutes by clarifying policies.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The administrative regulation affects physicians enrolled in the Medicaid program. Currently, there are over 14,000 individual physicians and over 1,700 physician group practices participating in the Medicaid Program. Medicaid recipients who receive services (including physical therapy services, speech pathology services, or sleep disorder services) will be affected by the amendment.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No action is required by providers other than to ensure that they provide services appropriately in accordance with the program requirements.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost is imposed on providers.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): As a result of complying with the administrative regulation, Medicaid-enrolled physicians will be reimbursed for services provided to Medicaid recipients.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost as a result of the amendment.

(b) On a continuing basis: DMS anticipates no additional cost as a result of the amendment.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish or increase any fees.

(9) Tiering: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10), 42 U.S.C. 1396a(a)(19), and 42 C.F.R. 447.26.

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(10) mandates that a state's Medicaid Program cover physician services. 42 U.S.C. 1396a(a)(19) requires Medicaid programs to provide care and services consistent with the best interests of Medicaid recipients.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment does not impose stricter, additional or different requirements than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect all physicians enrolled in the Medicaid program who are not reimbursed via a managed care organization.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 42 C.F.R. 447.26 and this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate any additional revenue for state or local governments during the first year of implementation.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate any additional revenue for state or local governments during subsequent years of implementation.

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional cost as a result of the amendment.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation: No additional expenditures are necessary to implement this amendment.